Provider Manual

Mental Health Services Of Catawba County

Forward

This manual is designed to try and bring a sense of true partnership to the MH/DD/SA service and support contracting process. It is not designed as a way to eliminate all potential problems, but rather as a way to begin the process of mutually identifying how we can go forward in our quest to seek best practice for the consumers of our services and in our business practices that we might be more effective and efficient. We hope that we can become true partners through demonstrating the mutual respect that is embodied in this effort. As we collaborate to seek quality and fairness in our relationships and business practices we can make the system more "friendly" to all of the participants in it. Let us each take responsibility for our own behavior. Let us be willing to not just seek the status quo, but rather a new and better way.

part-ner-ship (pärtˈnər-shipˈ)*n*. A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal. (Webster's).

TABLE OF CONTENTS

INTRODUCTION

This Provider Manual is a binding part of the contract or "Purchase of Services Agreement between the Area Authority and the Provider." The intent of this manual is to provide detailed information and procedures required as part of the purchase of service agreement and to organize this information in a common manner that is "user friendly" to all parties. It is also hoped through this process that increased standardization can begin to occur with business practices among Area Authorities.

Standardization should not be confused with uniformity. Specific Area Authorities currently have differing systems within their internal organizations just as private providers do, even though they may offer the same range of services. Some Area Authorities must operate under different or additional requirements and/or constraints than other Area Authorities due to local governance. This is similar to private Providers who have differing entities to whom they are responsible even though two or more private Providers may offer the same range of services. Some of these differences may begin to diminish as Area Authorities transition to LME's.

All activities carried out by contracted providers must conform to the provision of the DHHS/LME Performance Contract, and comply with the applicable provisions of federal and state laws, regulations and policies.

This manual does not include information about Area Authority policies or procedures that take place prior to contracting with a Provider, such as procedures for getting on the Area Authority's Provider network, or compliance verification, or checklists of items needed in order to begin the contracting process, etc. Rather, it includes only information pertinent to the performance of the Agreement.

There are multiple references throughout this document to annual versions of the *State Plan: Blueprint for Change*, and the North Carolina Division of MH/DD/SA website, www.dhhs.state.nc.us/mhddsas/. Hereafter, State Plan references will be indicated by **SP** and accompanying pages/sections, and the website will simply be noted as the Division's website (without accompanying web address).

The terms LME and Area Authority are interchangeable within this document.

This manual contains eight major sections. Please refer to the Table of Contents.

Providers will be notified of substantive changes to the Provider Manual as applicable, and Providers are responsible for implementing and adhering to the most current expectations outlined.

Brief Overview of the LME

Under the leadership of John Hardy, Area Director, Mental Health Services of Catawba County (MHSCC) has committed to the oversight and management of state-funded MH/DD/SA services for Catawba County citizens, along with working to assure community resources to meet the needs of consumers with less acute needs.

Units and subunits within MHSCC are identified below, along with some of their primary functions.

Consumer Services

Access/Emergency Services

- Triage all calls for services
- Initial authorizations for services
- Tracking provider responsiveness for service availability
- Emergency coverage for consumers not yet in MH/DD/SA system

Psychiatric Services

CAP Case Management

Administrative Services

Provider Relations/ Quality Management

Service Management

- Utilization management
- Care Coordination

MIS

Consumer Affairs and Community Initiatives

- Consumer Complaint/Grievance Process
- Client Rights
- Consumer Advocacy
- Guardianship

Finance/ Budget

- Internal account reconciliation
- Financial State reporting
- Provider Claims Adjudication
- Provider Billing/Payment

Reimbursement

Billing System Coordination

Section I
Provider Relations

Problem Resolution/Disputes and Appeals: ***If problems arise between the Provider and the Area Authority in the delivery of services, the parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4 shall be followed.***

MHSCC has appeal processes for both consumers and providers should concerns or disagreements with decisions/actions by the LME occur. As applicable, consumers would first engage the appeal/grievance process of the Provider with whom they are working, prior to that of MHSCC. The following procedures outline Consumer and Provider appeals, along with contact information. Additionally, information regarding the appeal rights of Medicaid-eligible and Medicaid recipients is outlined on the Division website under "For Consumers" and "Medicaid Rights". (Also see Section III of this Manual, outlining responsibilities for Notification of Service Denial, Suspension, Reduction or Termination)

Consumer Appeals – Contact John Waters

Any consumer who has a complaint/concern about the Provider from whom he/she is receiving treatment would first address those concerns directly with the Provider. Providers should make their organization's complaint/grievance process known and readily available to consumers, so that resolution may be reached at the lowest administrative level possible.

If the Provider from whom the consumer is receiving services has no Client Rights committee for the hearing of grievances, and the Provider has previously arranged with the LME to use the Area Authority Client Rights Committee, the consumer/Provider should contact the LME to access the grievance process according to the Provider Organization's Consumer Appeal policy and procedure.

If a consumer has a concern about issues directly related to the Area Authority, the consumer would contact the LME Community Affairs and Community Initiatives Unit.

The Division is currently in the process of standardizing the consumer appeal process, so information will be shared further as that is finalized.

*Note: Any Medicaid or Medicaid-eligible consumer has the right to pursue the Medicaid appeal process reference above *in addition to* or *exclusive of* the Consumer Appeal process just outlined.

Resolution of Disputes with Contract Providers – contact Doug Gallion

MHSCC will make every effort to attempt resolution through a local review process of any current or former contractor disputes originating within twelve (12) months of the service event in questions.

Terms are defined as follows:

- Contract – a contract with an area program to provide services, other than personal services, to clients or other recipients of services
- Contractor – a person or provider who has a contract with MHSCC, or who had such a contract during the fiscal year.
- Former Contractor – a person or provider who had a contract with MHSCC during the previous fiscal year.

Procedure

1. The first step toward problem solving and dispute resolution shall consist of informal discussion between a contractor or former contractor and the Director of Provider Relations within the LME.
2. If the informal resolution process is unsuccessful, the contractor shall put the dispute in writing, including a suggestion for appropriate resolution. The written request for resolution shall be mailed to the Administrative Services Director of the LME, clearly stating that such correspondence is being sent pursuant to the resolution of dispute policy. Copies of such correspondence are not to be distributed at this time to anyone outside the involved parties.
3. The Administrative Services Director of the LME shall have 15 working days in which to conduct an investigation and render a written opinion. The suggested solution may be accepted, modified, or rejected.
4. If the resolution offered by the Administrative Services Director was unsatisfactory or there was failure to meet the 15-day timeframe, the contractor or former contractor may appeal to the Area Director of the LME. The written appeal must be made within 15 working days of the prior written opinion. At this time, documentation must be submitted that the review is being made with the full knowledge of the Chief Administrative Officer or Chairperson of the contract provider organization's Board of Directors.
5. The Area Director of the LME will schedule a hearing for representatives of the contract provider and the LME within 15 working days. The Area Director shall render a written decision within 15 working days of the hearing.
6. The determination of the Area Director shall be final except where:
    - A contract provider or former contract provider claims the Area Authority is not acting or has not acted in conformance with applicable state law or rules in imposing a particular requirement on the contractor.
    - A contract provider or former contract provider claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract.
    - A contract provider or former contract provider claims that the Area Authority has acted arbitrarily and capriciously in reducing funding for the type of service provided by a contractor
    - A client or person who was a client in the previous fiscal year claims the Area Authority has acted arbitrarily and capriciously in reducing funding

for the type of service provided or formerly provided to the client directly by the Area Authority.

- A person claims that the Area Authority did not comply with a state law or rule adopted by the Secretary or Commission in developing the plans and budgets of the Area Authority, and further that the Area Authority's failure to comply has adversely affected the ability of the person to participate in the development of the plans and budget.

7. The LME may, in its sole discretion, retain the services of a mediator to assist with any part of the foregoing process.
8. The Area Director shall notify the Executive Committee of the Area Board at their next meeting of any provider disputes that have been heard, and the decision rendered at the Area Director level.
9. For provider complaints that meet the criteria outlined in Section 6, either party may request a review through the Area Board Chair to the Area Board Executive Committee. A copy of the complaint is to also be sent to the Area Director and other party. At this point the contract provider may, at their discretion, notify other persons that satisfactory resolution of the dispute at earlier levels of the established procedure have failed and are now advancing to the last local level of review. The last local review level designated is to the Executive Committee of the Area Board.
10. The Executive Committee shall give all parties the opportunity to be heard no later than the next regularly scheduled meeting of the Executive Committee, unless mutually agreed otherwise. The Executive Committee shall render a decision within 15 days of the hearing. The Committee may confirm the determination of the Area Director or propose an alternative. Unless the Executive Committee determines otherwise, from the point of view of the Area Authority, the Committee's determination is final and shall be reflected in the Committee's minutes.
11. In accordance with GS 122C-151.4, if the contract provider or other person (as described in Section 6) takes issue with the Area Authority's actions as determined by the Executive Committee, the contract provider or person may appeal to the State's Area Authority Appeals Panel established by the Secretary of the Department of Health and Human Services, according to rules determined by the panel.

Technical Assistance/Training Collaboration: ***Area Authorities shall provide timely and reasonable technical assistance regarding new State initiatives, or as the result of monitoring activities as related to the services covered in the Agreement, subject to the State's timeliness and availability of the information necessary to provide the technical assistance. Providers shall give reasonable notice to the Area Authority for any and all requests for technical assistance. Training collaboration shall be done whenever feasible between the Area Authority, or groups of Area Authorities, and Providers, or groups of Providers, in order to effectively and efficiently utilize the resources available to each party.***

Providers are responsible for arranging training for staff as required for service provision and/or licensure requirements as applicable (e.g., Bloodborne Pathogens, Medication Administration, First Aid, CPR, Defensive Driving, etc.)

The Provider Relations unit of the LME will be working on generating referral sources for these trainings and/or offering some limited capacity for providing trainings in the future; however, these resources will need to evolve. Staff training needs, both clinical and technical, may be presented to the Provider Relations unit for discussion or resource availability and how those needs may best be met.

The process for requesting technical assistance (TA) or training is as follows:

The Provider will make a written request to the Area Director of MHSCC requesting technical assistance. This written request should include the problem area(s) with which the Provider needs technical assistance from MHSCC, along with the name, address, and telephone number of the person initiating the TA request. The Area Director will contact the Provider and negotiate rates and times for providing TA as requested.

Technical assistance may be requested in the following areas:

- Billing
- Client Rights
- Documentation
- HIPAA
- Medical Records
- MIS
- Outcomes
- Quality Assurance
- Quality Improvement
- State Standards
- Staff training
- Other (to be specified by Provider)

Note: Agency expectations and agency business requirements/practices thoroughly covered in the annual Provider orientation are not considered technical assistance, and have no charge.

Providers need to send written TA requests to:

John M. Hardy, Area Director
Mental Health Services of Catawba County
3050 11th Avenue Drive SE
Hickory, NC 28602

<u>Who To Contact for Questions</u> (Please call 828-695-5900 and ask for the person listed below)

Agreement Questions	**Patsy Hill**
Monitoring Questions **Credentialing/ Privileging** **Accreditation** **Licensure**	**Doug Gallion**
Liability Insurance	**Patsy Hill**
Authorizations	**Karen Curtis-Gwynn**
Invoices	**Janet Goforth**
Payment	**Janet Goforth**
Medical Records	**Wendy Powers**
Quality Assurance	**Doug Gallion**
Clinical Concerns	**Melissa Cline**
Treatment Plans	**Consumer's case manager Or primary therapist**
General Concerns	**Sonja Bess**

<u>Notification of Change of Address:</u> ***Formal notification of change of address of either party shall be given to the other.***

Providers are to notify Contract Manager in writing of all changes in address. These may be sent to:

Patsy Hill, Contract Manager
Mental Health Services of Catawba County
3050 11th Avenue Drive SE
Hickory, NC 28602

Area Authority will also notify Providers in writing in the event of any change of address.

Communication between Providers and Area Authority will also be expedited if each informs the other of any changes in phone or e-mail, though this notification is not required in writing.

Section II

Comprehensive List of State and Federal Requirements for The Area Authority and Provider

The document below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement.

These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and Area Authorities to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an Area Authority has concerns about how a change will be implemented, then the Area Authority shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the Area Authority for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at the Area Authority: Sonja Bess, Director of Administrative Services

Comprehensive List of State and Federal Requirements for The Area Authority and Provider

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) **APSM 45-1** (Confidentiality) **APSM 45-2; 45-2a** (Service Record Manual) **APSM 95-2** (Client Rights) **APSM 10-3** (Records Retention and Disposition Schedule) **APSM 75-1** (Retention of Financial Records)	**Contact:** Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance www.dhhs.state.nc.us/mhddsas/manuals
CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	**Contact:** Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	http://www.dhhs.state.nc.us/mhddsas/developmentaldisabilities/operations/index.htm
Medicaid-Related Documents Medicaid-covered services definitions Medicaid Services Guidelines Medicaid Communiqués	**Contact:** Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	http://www.dhhs.state.nc.us/mhddsas/medicaid/index.htm
NCAC 16 A 0400 (Single Portal Requirements)	**Contact:** Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	Not currently available on-line
Residential Licensure Requirements	(919) 855-3750	http://facility-services.state.nc.us/provider.htm
Health Care Personnel Registry	(919) 733-8500 or (919) 715-0562	http://facility-services.state.nc.us/hcarpage.htm and www.ncnar.org
SB 163- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm

State Level		
General Statutes **122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985** Applicable sections include but are not limited to: ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase "client or his legally responsible person ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions… ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of Corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, no prohibited ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc.		All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site. www.ncleg.net
DHHS Disaster Preparedness, Response and Recovery Plan		(Not yet available)
SB 163- Monitoring of Providers		http://www.dhhs.state.nc.us/mhddsas/sb163/index.htm
Performance Agreement(03-04) between DMH and Area programs-Attachment 12-prompt pay		www.dhhs.state.nc.us/mhddsas/performanceagreement
Contract between the Area Authority and the NC division of MH/DD/SAS		http://www.dhhs.state.nc.us/mhddsas

Federal level		
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/drugfree.htm
Section 503 and 504 of the Rehabilitation Act of 1973	Library –Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eeo
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html
Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16	Library-Federal Laws	www.dol.gov
Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons	Library-Federal Laws	http://thomas.loc.gov/bss/d099/d099laws.html Search for 99-320
▪ Title I Protection and Advocacy Systems ▪ Title II Reinstatement of Rights for Mental Health patients		http://www4.law.cornell.edu/uscode/42/ch114.html
Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988	Library-Federal Laws	http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-509 http://www.oxfordhouse.org/fairhouse.html
Public Law 101– 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990	Library-Federal Laws	http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-496
42 CFR Part 2 Confidentiality Regulations 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://www.gpoaccess.gov/cfr/index.html
Office of the Inspector General (Exclusions - "Lower-tier Transactions and disbarment")	Library – Federal Laws	http://oig.hhs.gov/fraud/exclusions.html
Pro-children Act Section 1041-1044 of the Educate America Act of 1994 prohibiting smoking in areas used by children.	Library – Federal Laws	http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html
Americans with Disabilities Act	Library – Federal Laws	http://www.usdoj.gov/crt/ada/adahom1.htm
OTHER		
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Area Authority/LME -Specific		
Local Business Plan		www.catawbacounty.nc.gov/MentalHealth/
Local Policies and Procedures		

Section III
Access, Referral and Authorization Process

The Area Authority will continue to serve as the primary portal of contact and entry for a consumer to begin MH/DD/SA services in the community. Telephone access will be available 24/7 year-round, with expanded walk-in capacity and ongoing Emergency coverage in partnership with the 911 system and local hospital Emergency Rooms. This Emergency coverage is strictly for consumers who are new to the MH/DD/SA system and have not yet been established with a Provider within the community. Once a consumer is associated with a Provider, routine and emergency coverage of that consumer is the responsibility of the Provider.

The Area Authority has sole discretion in making referrals to Providers. It is the goal of the Area Authority to find the service provider which best matches the consumer's needs, while at the same time maintaining consumer choice and remaining consistent with clinical protocols established by the Area Authority.

A consumer's choice of provider, from among enrolled providers, shall be honored by the LME, subject to medical necessity and utilization review criteria and, for State and State-allocated funded services and consumers, the LME's provider subcontracting policies and procedures.

It is the responsibility of the Provider to assure Medicaid eligibility and/or State-supported program eligibility of the consumer.

It is recommended that screening and triage activities for all services with new consumers come directly through the Access Unit. This allows a consistent evaluation and disposition, with all information gathered only once on the consumer. The Access Unit is additionally responsible for tracking several elements such as time, place, and outcome of referral, so the direct route through the Access Unit expedites this information-gathering.

The Area Authority Access Unit serves as the single portal of entry and exit from State facilities. Should a need arise to use one of the State facilities, the LME Access Unit must be contacted to process and authorize the referral. All State psychiatric and substance abuse facility discharges must be seen within 5 working days. Additionally, discharges from any other inpatient and substance abuse facility must be seen within 5 working days.

The Area Authority serves as the administrator for State detoxification funding. These dollars are available for indigent clients who have no financial resources, who are residents of Catawba County, and are in need of either medical detox services or medical non-hospital detox services. The LME Access Unit must be contacted to authorize and process these referrals.

<u>For outpatient services</u>:
If a consumer initially comes to the Provider rather than through the Access Unit of the LME, it is recommended that the Provider route the consumer to the Access Unit for screening/triage/referral. This may be done by telephone linkage, or in person.

If the Provider chooses to do the screening/triage function, it is the responsibility of the Provider to provide documentation of the screening procedure and disposition, and provide the Access Unit with all tracking information to meet the LME access to care monitoring requirements.

Medical Necessity criteria are to be followed by the Access Unit and the Provider. Screening efforts should result in determining if an individual in is an emergency condition or if the issues would best be categorized as urgent or routine. **Emergent** needs are to be addressed within two hours; **urgent**, within 48 hours; **routine**, within 7 calendar days.

Currently, several processes for authorization are in place due to transitions and divestiture efforts. The plan is to move all outpatient service providers to the procedural process outlined below. ***HOWEVER, until a Provider has been given individualized training in the authorization process from the LME, processes currently in place are to be followed****. Questions may be directed to Karen Curtis-Gwynn of the Service Management/Utilization Management (UM) Unit of the LME.*

- The Provider must obtain an authorization number from the Area Authority prior to seeing and providing outpatient services to an adult or child consumer for the first time. The Provider will contact the Access Unit and provide the following information for tracking/authorization purposes:
    - Client Name
    - Address
    - Date of birth
    - Social security number
    - Gender
    - Competency status/ legally responsible person
    - Telephone number
    - County of residence
    - Ethnicity
    - Language
    - Marital status
    - Race
    - State of residence
    - Ability to pay
    - Commitment status
    - Education level
    - Employment status
    - Living arrangement at admission
    - Admission referral source
    - Tentative diagnosis
    - Anticipated treatment needs
- The Access employee will give the provider an authorization number to provide one initial assessment, to be completed within 30 days. Once the consumer has completed the assessment, the Provider will call the Access Unit for additional authorization – 7

outpatient sessions for adults, or 25 outpatient sessions for children. If the consumer is Medicaid eligible, the initial authorization is effective through December 31 of the calendar year, not exceeding the numerical units of service. If the consumer is NC Healthchoice eligible, the initial authorization is effective to June 30 of the calendar year, not exceeding numerical units of service.

- Within 3 business days following the initial assessment of a consumer, the Provider will forward the following to the Area Authority's Medical Records Department:
    - Facesheet
    - Signed Service Order (Service Order must be signed prior to or on the same date as service delivery, signed by an MD or PhD)
    - Admission Assessment
    - Plan of Care (Treatment Plan), signed by primary therapist and client and/or guardian
    - LOE, CAFAS or NCTOPPS, as applicable
    - Target Population Assignment Form
    - COI (Client Outcomes Initiative), as applicable on client numbers ending in 3 or 6
    - Copy of the Medicaid card

  The Provider is expected to follow Medical Necessity Standards in service assignment and provision.
- After the 6th session for adults and the 20th session for children, reauthorization for outpatient services may be requested. All reauthorization requests for consumers will be sent to the Service Management/UM unit of the LME. This reauthorization will include a request for additional sessions with a copy of the Plan of Care (only if there have been changes since the original authorization), along with clinical justification and supporting documentation as needed. The reauthorization form should have all blanks completed with information, or have N/A in the blank. **Additionally, reauthorization requests for Medicaid-eligible clients must be completed on a Value Options Outpatient Treatment Report (OTR); the OTR should be forwarded to the Medical Records Department of MHSCC so that it may be faxed to Value Options.** Within three working days, the UM unit will approve, pend, or deny the reauthorization request and then notify the Provider by e-mail of their decision.
- Clinically approved reauthorizations will be forwarded to the Finance unit so that financial authorization can be established; a financial authorization will be rendered within 5 working days. The contracts manager will forward a consumer-specific contract attachment to the Provider, including a copy of the reauthorization information. Authorizations will be matched against invoiced services. The Provider will submit a Discontinuation of Services Report form to the LME when services are terminated.
- If the consumer is Medicaid eligible, it is the responsibility of the Provider to assure Medicaid eligibility.
- Once a Provider has accepted a referral, it is expected that the Provider will complete all outpatient counseling services. The Area Authority will act on referral requests within 5 working days.
- The Division of Medical Assistance (DMA) will be notified of any incident whereby a Provider uses the Area Authority's referral number for services delivered to consumers without Area Authority approval.

SERVICE EXPECTATIONS

- It is expected that the Provider will have the capacity and assume responsibility to provide and/or coordinate psychiatric services for their active clients, as clinically indicated.
- It is expected that the Provider will have the capacity and assume responsibility to provide after-hours emergency coverage for their active clients.
- Providers are to use Best Practice treatment protocols for the populations served. Best Practice scope and definitions are referenced in annual State Plans, and referenced in Section VI of this Provider Manual.
- All Providers of services on a consumer's PCP are to coordinate and communicate on treatment interventions and progress, so that integration is maximized for the consumer's benefit.
- PROVISION OF CASE MANAGEMENT SERVICES – If the Provider deems other services to be necessary for the care of the consumer, arrangement must be made for a case management referral. Case management will be the means by which all other services are coordinated; however, this does not preclude the Provider's responsibility to participate in the treatment team process and to ensure accurate goal development and maintenance. **The Provider will directly call the Agency providing case management services, and request a screening.** Prior to that screening appointment, the Provider will send copies of the following to the case management provider agency:
    - Face Sheet
    - Admission Assessment
    - Plan of Care
    - Signed service order
    - LOE/CAFAS
    - Target population form
    - COI or NC TOPPS, as applicable
    - Copy of Medicaid care

  The case management provider Agency will request an authorization for a screening through the Service Management/UM Unit of the LME. The case management provider Agency will conduct the screening, and if it is deemed that case management is necessary, the case management agency will forward the following to the UM Unit:
    - Updated plan of care
    - Signed service order
    - Authorization request for case management services
    - All other information listed above, received from the original Provider

  Within three (3) working days, the UM Unit will approve, pend, or deny the case management authorization request, and notify the provider by e-mail of the decision.
- TREATMENT TEAM PLANNING AND CARE COORDINATION – Many clients receive services from multiple agencies, in multiple settings, and utilizing multiple service types. The Provider must be closely aligned with all service providers to ensure appropriate coordination of care and follow-up. Provider should attend all Child and Family Team meetings, and will be responsible for ensuring their service documentation in the integrated Plan of Care.

Authorizations for services other than Outpatient Services
Based on a Person-Centered Plan developed and maintained by the consumer's case manager, services requiring authorization should be addressed directly with UM, using the processes currently in place. Questions may be directed to Karen Curtis-Gwynn in the Service Management/UM Unit of the LME.

Notice of Service Denial, Suspension, Reduction or Termination

Should the UM Review and decision about services result in a service denial, the LME UM Unit has the responsibility of informing Medicaid or Medicaid-eligible clients as outlined in the Medicaid Appeal Process.

If a Provider has been given authorization to provide services, and subsequently decides to suspend, reduce or terminate those services, the Provider has the responsibility of informing Medicaid or Medicaid-eligible clients as outlined in the Medicaid Appeal Process. The LME will monitor that this notification takes place as legally prescribed.

The Medicaid Appeal Process, notification letters, notification timelines, etc. is available on the Division website under "For Consumers" and "Medicaid Rights". Forms are available in English and Spanish, including Medicaid Appeal brochures, Hearing Request Form, Flowchart, and Form letters. ***All forms must be customized with your agency's specific contact information***.

Section IV
Claims

Area Authority/LME Fee Collection Policy and Minimum fee/sliding scale fee schedule:

Information will be supplied as available**.**

Claims Filing Requirements/ Claims Adjudication:

If the provider bills within sixty (60) days of providing a service, the LME will pay claims in accordance with the Division of MH/DD/SA prompt pay requirements.
The LME shall honor provider billings as long as they are filed in time to meet DHHS billing requirements. For Medicaid services billed through the LME, billings will be honored for up to twelve (12) months from the date of service; however, billings submitted beyond 60 days after service provision are not held to prompt pay requirements.

Prompt pay requirements are set forth as follows:
Within eighteen (18) calendar days after the LME receives a claim from a provider, the LME shall either

- Approve payment of the claim
- Deny payment of the claim, or
- Determine that additional information in required for making an approval or denial

If the LME approves payment, the claim shall be paid within thirty (30) calendar days after making approval.

Providers are encouraged to submit billing twice monthly, by the 5th and 25th of each month. The invoices supplied with the Provider contract are set up in 15-day cycles to support this frequency of billing, which in turn keeps a steady revenue flow. Invoices may be mailed, delivered in person, or sent via e-mail to Janet Goforth (janet@catawbacountync.gov) if encryption software specifically provided by the Area Authority is used. **Invoices may not be faxed**. Along with invoices, Providers are asked to send copies of the Medicaid card of the billed consumer.

Invoices are matched against authorized services and the time range of authorization. A claim must be resubmitted within 60 days if it is denied. Any invoiced service that was provided without appropriate authorization will be denied payment.

Other than grant invoices, generally a Provider may expect a 48-day wait between the time an invoice is submitted and payment is received on an approved claim.

All payments for services to providers shall be provisional and subject to review and audit for their conformity with DHHS requirements. The parties to this Contract should agree and understand that the payment of the sums specified in the Provider contract is dependent and contingent upon the appropriation, allocation and availability of funds for this purpose to DHHS and the Area Authority.

The LME shall work with its providers to pursue all applicable first and third party payments for services in order to maximize the usage of public resources. The LME and/or contract providers shall obtain all relevant payer information from each consumer to be served, his/her guardian and/or family. This information should be collected at the consumers' first encounter with the LME or its contract provider, but no later than the submission of the first claim for service. The LME shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information, if applicable.

Electronic Connectivity Requirements:

Currently there are no connectivity requirements for Providers within the MHSCC Provider network.

Payment Schedules:

Medicaid check-write schedule is available on the following website: dhhs.state.nc.us/dma/. Typically it is on the last page of the Medicaid bulletin, under publications subsection. The IPRS check-write schedule is the same as Medicaid, except for IPRS timely filing provisions.

- All claims from July to April 30 must be submitted and processed by IPRS before the last IPRS check-write in June, otherwise there will be a denial based on not meeting timely filing provisions.
- All May and June service claims must be submitted and processes by IPRS before the last IPRS check-write in August.

Prompt Pay:

Please refer to Prompt Pay provisions explained in the Claims Filing Requirements/ Claims Adjudication paragraph in this Section. Additionally, Prompt Pay is explained in detail below.

Prompt Pay Provision
(Attachment 16, 03-04 Performance Agreement)

Definition:
As used in this section, "provider" means any qualified public, or private, provider, agency, institution, or resource that contracts with the Area Program for the provision of services pursuant to G.S. 122C-141 (a).

Invoice Processing Period Requirements:
Within eighteen (18) calendar days after the Area Program receives an invoice from a provider, the Area Program shall either: (a) approve payment of the invoice, (b) deny payment of the

invoice, or (c) determine that additional information is required for making an approval or denial. The foregoing requirement is further specified in the following bullets:

- If the Area Program approves payment of an invoice, the Area Program shall pay the invoice within thirty (30) calendar days after making the approval.

- If the Area Program denies payment of an invoice, the Area Program shall return the invoice to the provider and include notice specifying the full and complete good faith reasons for the denial within eighteen (18) calendar days after the Area Program received the invoice. The Area Program will have been deemed to have complied with this requirement if, on or before the eighteenth calendar day, the Area Program electronically transmits the invoice and notice to the provider, places the invoice and notice in the U.S. mail, first class postage prepaid, properly addressed to the provider, or makes actual delivery of the invoice and notice to the provider.

- If the Area Program determines that additional information is required for making the approval or denial of an invoice, the Area Program shall provide the provider with notice of the same. The notice shall contain the specific good faith reasons why the invoice has not been paid and furnish a complete itemization, or description, of all of the information needed by the Area Program to complete the processing of the invoice. The Area Program shall provide such notice to the provider within eighteen (18) calendar days after the Area Program receives the invoice. The Area Program will be deemed to have complied with this requirement if, on or before the eighteenth calendar day, the Area Program electronically transmits such notice to the provider, places such notice in the U.S. mail, first class postage prepaid, properly addressed to the provider, or makes actual delivery of the invoice and notice to the provider. Upon the Area Program's receipt of the additional information from the provider, the Area Program shall process the invoice within the time periods stated above for approving, denying, and paying invoices.

- The Area Program is not limited to paying an invoice in full, denying an invoice in full, or requesting additional information for an entire invoice. Rather, as appropriate, the Area Program may approve an invoice in part, deny an invoice in part, and/or request additional information for only a part of the invoice, as long as the Area Program either approves, denies, or requests additional information for each part of the invoice within the required eighteen (18) calendar day period. If the Area Program partially approves, denies, or requests additional information for an invoice, the Area Program shall take the appropriate further actions on the invoice within the applicable time periods specified above. For instance, if an invoice is denied in part and approved in part, the Area Program shall pay the approved portion of the invoice within thirty (30) calendar days after the approval and shall send the notice of denial for the denied portion of the invoice within eighteen (18) calendar days after the Area Program's receipt of the invoice.

- The Area Program is presumed to have received a mailed invoice five business days after the invoice has been placed in the United states mail, first-class postage prepaid, properly addressed to the Area Program, or an invoice transmitted electronically, to the Area Program or a designated clearinghouse, on the day the invoice is transmitted.

- All references to the term “invoice” in this Section, IV.A.3. “Prompt Pay Provision” shall include invoices for Medicaid services and invoices for non-Medicaid services, except for the references to “invoice” in the provision below captioned, “Submission of Non-Medicaid Invoices to Area Program,” which shall include only invoice for non-Medicaid services.

- In calculating any period of time prescribed by this section, IV.A.3. “Prompt Pay Provision,” the day of an act, or event, after which a designated period of time begins to run is not to be included. For instance, in calculating the eighteen (18) calendar days after an Area Program receives an invoice, the day the Area Program receives the invoice is not included or counted, and the first of the eighteen (18) calendar days is the calendar day that follows the day on which the invoice was received.

Funds Availability Provision:

The payment of funds by the Division to the Area Program, as specified by this Agreement, is conditioned upon the appropriation, allocation, and availability of the funds to the Division for this purpose. To this end, if it appears that the payments from the Division to Area Programs will be disrupted due to a statewide reduction in funding, the Division Director shall provide providers and Area Programs with prior notice of the reduction. This notification shall give direction to Area Programs about the appropriate course of action regarding payments to providers. In addition, in instances where the Area Program submits evidence to the Division that reasonably demonstrates that the Area Program’s late payment of invoices is the direct result of errors or delays by the State, or its contract vendors, the Area Program shall be exempt from the time periods imposed by this section for approving and paying such invoices. In such circumstances, the Area Program shall approve and pay the invoices within a time period that is reasonable under the circumstances. If, for any reason, the Area Program anticipates that it will be unable to make payment on an individual invoice within the time periods required by this section, and the Area Program and provider are unable to reach a resolution, the Area Program must obtain the prior approval of the Division in order to delay payment. Such requests will be reviewed on a case-by-case basis. Notwithstanding any of the foregoing, the Area Program’s duty to pay an approved claim within thirty (30) calendar days after approval is not conditioned upon the Area Program first having received payment from the State for the services covered by the invoice.

Submission of Non-Medicaid Invoices to Area Program:

Area Programs shall include in their contracts with providers provisions concerning the submission of non-Medicaid invoices that comport with the following:

- The provider shall submit invoices for non-Medicaid services in the appropriate form within the shorter of: (a) the time period stated in the contract between the Area Program and provider and (b) 15 calendar days after the end of the month in which the service(s) was rendered, or in which the consumer was discharged from service. Failure to submit an invoice within the time period shall exempt the Area Program from the time periods

imposed by this section for approving, denying, requesting additional information, and paying the invoice. In such circumstances, the Area Program shall process and pay the invoice within a reasonable time under the circumstances. If the Area Program denies payment of an invoice, the provider must resubmit the invoice, with full and complete information, as specified by the Area Program, within the shorter of (a) the time period stated in the contract between the Area Program and provider and (b) thirty (30) calendar days after provider's receipt of the denied invoice, unless the provider has received from the Area Program a waiver of the re-submission time period. Provider's failure to resubmit the invoice within forty-five (45) calendar days after provider's receipt of the denied invoice (absent a waiver from the Area Program) shall exempt the Area Program from the time periods imposed by this section for approving, denying, requesting additional information for, and paying the invoice. In such circumstances, the Area Program shall process and pay the invoice within a reasonable time period under the circumstances.

Third Party Beneficiary:

Any provider who submits invoices to the Area Program for services rendered shall be an intended third-party beneficiary of this Section.IV.A.3, and without limitation, the duties imposed upon the Area Program through this section are likewise duties owed to such provider, and such provider may enforce the performance of the duties.

Section V
Provider Documentation Submission Requirements

The purpose of documentation is twofold:

To adequately reflect the status of treatment as it relates to the treatment plan
To satisfy quantitative and qualitative requirements of the payer of treatment (e.g., Medicaid, state funds, private insurance, etc.)

Authorizations, billing and the collection of fees all hinge on appropriate and timely documentation. Inadequate documentation (e.g. missing documentation, lacking substance to justify treatment provided, late documentation) will slow and/or prohibit reimbursement, at times requiring payback of funds already received if a retrospective audit proves that documentation of those services was insufficient in any way.

All cases require the following:

- Service order dated **on or before** the date of the first service provided. The service order must indicate what services are "ordered" for a client, and be signed by an M.D. or Ph.D. Case management services are the exception, and may be ordered by a case manager.
- Admission assessment
- Level of Eligibility (LOE) or Child and Adolescent Functional Assessment Scale (CAFAS)
- Target Population Sheet
- Treatment Plan, including diagnosis, strengths, preferences, identified problems, goals, interventions for treatment, and dates of service…signed by clinician and client
- Progress Notes or Logs (dependent on service)…signed by clinician, with credentials
- Termination Summary

Some cases may additionally require:

- Medicaid Appeal letter, as applicable, for Medicaid clients for whom any services were reduced, suspended or terminated
- COI (Client Outcome Inventory) for case numbers ending in 3 or 6
- NC TOPPS
- ASQSE
- TB Screening Form
- Substance Abuse specific data

<u>General Medical Records Expectations</u>

- Both the Provider and the LME shall retain records in accordance with applicable law.
- Provisions of medical records accountability are available on the Division website under Publications/ Forms and Manuals. **APSM 45-2 Service Records Manual for Providers of MH/DD/SA services** contains information on service plans (Chapter 5), documentation signature/credential requirements, corrections, etc.
- Any information e-mailed about consumers should only include the consumer's first name and last initial, and/or case number

- CPT service codes can only be billed by PhD and MA Psychologists, LCSWs, LPCs, and Clinical Nurse Specialists

Assigning Principal and Primary Diagnoses
The following is a code structure for reporting to the Division using either axis I, II or III.

P – Principal Diagnosis
R – Primary Diagnosis
B – Both Principal and Primary Diagnosis
A – Additional Diagnosis

Principal diagnosis (P) – the condition established after study to be chiefly responsible for the admission of the client to the area program for care. (What brought the client to MHSCC for treatment?) The principal diagnosis may or may not be the same as the primary diagnosis, but it CANNOT be changed once established within the same admission. (This applies even if the principal diagnosis is no longer an issue and no longer being treated …it still must remain on the treatment plan. However, if no longer being treated, you would not have to have goals & interventions addressing this diagnosis). ***Note – The principal cannot be changed even if the client is being discharged from one disability and transferred to another.

Primary diagnosis (R) – other significant conditions of a client at any time during the course of treatment in terms of its implications for the client's health, medical care and use of facility resources. The primary diagnosis may or may not be the same as the principal diagnosis. The primary diagnosis may change over time within the same admission and the client may have more than one primary diagnosis.

Both Principal and Primary (B) – indicates that there is **only one** diagnosis on axis I and II that is being treated by the provider and therefore is BOTH principal and primary. Therefore, if you assign a (B), and have other diagnoses, they would be additional (A) diagnoses. They cannot be primary.

***If during the same admission another primary diagnosis is assigned toAxis I or II --- you can change the B to a P (principal diagnosis).

Additional diagnosis (A) – means any diagnosis other than the principal or primary diagnosis(es). It indicates conditions that the client has but may not be being treated at this time.

There is no limit on the number of diagnoses that you can have …However, CMHC only allows for three (3) Axis I and two (2) Axis II diagnoses per layer. If you have more than these, the support staff can layer these in CMHC. Only the top layer gets transmitted to the State so best practice would be to put an asterick * beside the ones that you want on the top layer. The principal diagnosis must always be on the top layer.

****Note to CAP Providers**: Follow the same guidelines except on the plan you will actually write out principal, primary, principal & primary or additional instead of using the P, R, B and A.

All clinicians should remember to coordinate diagnoses across providers.

Best Practice for Plans of Care (Treatment Plans)

The UM Team has reviewed the Service Records Manual, Medicaid guidelines and past audit evidence to determine best practice in regard to treatment plans. Best practice is as follows:

Revisions/Changes

- Any changes should be designated in the "review date" and "status code" boxes
- Change to goal
  - Put in review date
  - Put in status code
  - Put in justification
- Change to intervention
  - In the service/intervention section
    - Put As of (date): [put in BOLD letters so it stands out]
    - Add changes

Example:

Original Plan Date - 1/13/03

Goal	Service(s)/Interventions(s) (including frequency)	Responsible Person/Position
Problem # 3 Jeffrey sometimes forgets to put on clean clothes. He frequently puts on the same clothes after taking a shower. Goal **Jeffrey will put on clean clothes after showering with no prompts for 2 weeks as evidenced by CBS worker report.**	CBS paraprofessional individual services to assist Jeffrey in coming up with a strategy so that he remembers to put on clean clothes (i.e. putting his dirty clothes in the clothes hamper when he gets undress). CBS paraprofessional individual services to assist Jeffrey in selecting clean clothes to wear that day as needed. Frequency**:** 25 hours a week of CBS paraprofessional individual services applied to goals 3,4 & 5 **As of Nov. 17, 2003** Revised: CBS paraprofessional individual services to assist Jeffrey in preparing his clothes (selecting appropriate clothing per the weather, clothes that match, clean clothes, ironing clothes if needed, etc.) that he will wear the next day. CBS paraprofessional individual services to teach Jeffrey to do his laundry (i.e. sorting clothes, setting washer and dryer, putting clothes away, etc.) CBS paraprofessional individual services to provide verbal prompts or physical assistance as needed. **Frequency:** up to 20 hours per week of CBS paraprofessional individual services applied to goals 3, 4 & 5	Jeffrey CBS paraprofessional individual services

Target Date	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Outcome:
01/12/2004	11/12/03	O	Client has shown some improvement but continues to need CBS services to maintain current level.

- Changes that warrant signatures:
  - Addition of goal
  - Change of goal
  - Change in intervention frequency (ie. Reducing CBS to 20 hours weekly from 25 weekly)
  - Changing or extending a target date
  - Change of responsible person

- If responsible person changes (ie. Client no longer receives Medicaid & no longer qualifies for CBS services – the client is now going to receive personal assistance but the goals and interventions will stay the same) --- You would revise plan the same as example above except put change in the responsible person/position box.

- THE PLAN THAT YOU ARE REVISING SHOULD NEVER BE REMOVED FROM THE RECORD OR DESTROYED. You should add the new sheet where changes were made but leave the old one in the chart as well.

- There are methods of just printing out the page you made the revision/change to ---- You do not need to print out the entire plan and put in chart.

Signatures

- Annual review: ALL responsible persons and client/legal guardian must sign
- Review/Change: Just the staff reviewing and client/legal guardian must sign
- Review Only: Medicaid guidelines and the Service Records Manual states that even if NO changes are made, still MUST get signatures (this includes changing or extending a target date).
- Clinicians that do Groups: Must sign all treatment plans of clients in your group
- Signatures should be obtained at review **AND** on the effective date if they differ. Signatures should be obtained when a treatment team meets. Once the plan is finalized and dated, another client signature should be obtained. The client signature should match the date of the plan or revision. In the example above, you would need a client signature for 11/12/03 (date team met) and 11/17/03 (date revision was finalized). ******NOTE – A PLAN IS NOT CONSIDERED FINALIZED UNTIL IT HAS ACTUALLY BEEN WRITTEN & SIGNED.**
- If unable to obtain signature – clinician should date and sign, in the box for client/legal guardian signature, write "unable to obtain signature – refer to progress note". Clinician should then write a short progress note explaining the circumstances of why the signature could not be obtained.

Updating Entire Plan before Due Date

You can change the plan date before the due date --- However, you must complete all paperwork that goes with a regular update (LOE, Target Pop, etc.)

Section VI
Quality Improvement and Performance Monitoring

Provider Monitoring:

Senate Bill 163 (SB163) was enacted in October, 2002. The provisions were made retroactive to July 1, 2002. The purpose of SB163 was to implement the recommendations of the Legislative Research Commission Study on group homes to address licensure issues and the needs of local school administrative units in which group homes for children were located.

Within SB163 was language that is now written into statute for MH/DD/SA, 122C-11, which reads:

The area authority or county program shall monitor the provision of mental health, developmental disability, and substance abuse services for compliance with the law, which monitoring shall not supercede or duplicate the regulatory authority or functions of agencies of the Department.

Components within Permanent Rule:

- Area Authority is required to monitor all MH/DD/SA services within the catchment area.
- Area Authority is required to receive, resolve, refer or investigate complaints made to the LME regarding the provision of MH/DD/SA services.
- Area Authority is required to receive and review incident reports, and identify trends based on those reports
- Providers are required to send the Out of Home Community Placement Form (see detailed explanation below)
- Providers are divided into categories for the purpose of differentiating levels and intensity of monitoring.
    - **Category A** – facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals; these include 24-hour residential facilities, day treatment and outpatient services
    - **Category B** – Community-based providers not requiring State Licensure (including, but not limited to CAP-MR/DD service providers, and homes for one adult)
    - **Category C** – hospitals, state-operated facilities, nursing homes, adult care homes, family care homes or child care facilities, and
    - **Category D** – individuals providing only outpatient or day services and are licensed or certified to practice in the State of North Carolina

The LME is establishing policies on provider monitoring.
The frequency and extent of local monitoring will be based on:

- Number and severity of Level II/ Level III incidents reported by the provider, and the provider's response to the incident
- Provider's compliance with the reporting requirements
- Number and types of complaints received concerning a provider, and the provider's response to the complaints
- Conclusions reached from complaint investigations
- Results of reviews conducted by DFS, DMH/DD/SAS or DSS
- Compliance with the requirements of the provision of public services

- Addition of a new service
- National accreditation (COA, JCAHO, CARF)

The referral of LME Local Monitoring to the appropriate State Agency will be based on:

- Local monitoring identifying an issue a State agency is required to review
- A Plan of Correction resulting from local monitoring is not submitted to the Area Authority within the designated timeframe
- Issues identified in a local monitoring report are not corrected by the provider
- The Area Authority is the provider of the service to be monitored
- An appeal of the results of local monitoring

A Provider Monitoring checklist is in accompanying packet of forms, outlining areas to be monitored.

The LME will communicate results of Local Monitoring to the Provider within ten (10) days, including:

- Identification of each service monitored
- Identification of any issues requiring correction
- Timelines for implementing the corrections (not to exceed 60 days from the date the Provider receives the Local Monitoring Report)

Other requirements include:

- Providing a copy of the Local Monitoring Report to the client's home Area Authority (if different) upon request, within ten (10) days of completion
- Submitting reports of Local Monitoring activities to the State not less than monthly, including:
    - Identification information for providers monitored during the reporting period
    - Whether issues requiring correction were identified
    - An explanation of any uncorrected issues

Provider Reporting and LME Analysis will be done for the following purposes:

- To ensure consumer health, safety and rights protection
- To improve the quality of services
- To guide consumers' choice of providers
- To give stakeholders and the public confidence in the MH/DD/SA system
- To support requests for funding

Mental Health Services of Catawba County shall ensure that providers meet with the parent(s) or legal guardian and other representatives involved in the care and treatment of the child or adolescent, including local DSS, local education agency and criminal justice agency, to make service-planning decisions prior to the placement of the child and adolescent out of the home community.

MHSCC shall ensure the notification of placement. Providers are responsible for sending the notification of placement form via email, fax or hard copy within three business days after out of home placement occurs. In case of an emergency, notification may be by telephone with written notification occurring the next day. The following entities shall be notified:

1) Legal guardian
2) Other representatives involved in the care and treatment of the child or adolescent
3) Host community provider
4) Host community representatives (may include court counselor, county DSS, regional Children's Developmental Services Agency or the local education agency

Notification shall be completed on a form provided by the Secretary, to include the following information:

1) Child or adolescent information: name, date of birth, grade, identification number, social security number, date of placement out of home community
2) Parent/legal guardian information: name, address and telephone number
3) Home and host DSS information: county, contact person name, address and telephone number
4) Home and host area authority/county program information: name of program, contact person name, address and telephone number
5) Home and host school information: school name, address, telephone number, principal, special education program administrator
6) Person completing notification form information: name, date form completed, agency, address and telephone number

This Notification of Out of Home Community Placement for Children/Adolescents Form is available on the Division website, and additionally in the attached packet of forms with this Provider Manual

Privileging/Competency Documentation/ Reporting:

Staff Credentialing and Competencies

State Standards (APSM 30-1) mandate that the qualifications, experience and credentials of each professional and paraprofessional staff member of any agency providing MH/DD/SA services will be examined. Clinical qualifications (Qualified Professional, Associate Professional, or Paraprofessional) will be granted to staff based on credentials and/or competencies, designating their eligibility to perform clinical duties independently or with supervision. Each employee providing direct consumer services must be appropriately credentialed and competent for services provided, based on agency policy and administrative rule 10A NCAC 27G.0104. The agency policy should reflect whether a competency-based or privileging system will be used, how often and under what circumstances credentialing/competencies will be reviewed, the procedure for establishment and maintenance, etc.

Competencies

Administrative Rule 10A NCAC 27G.0203 and 0204 specify that there shall be no privileging requirements for qualified professionals, associate professionals or paraprofessionals. A competency-based system, whereby a staff member demonstrates knowledge, skills and abilities required by the population served, may be established, additionally requiring policies and procedures for individualized supervision plans as applicable based on the Administrative Rules previously referenced. If reflected in the policy of the agency that a competency-based system of credentialing will be used, competence shall be demonstrated by exhibiting core skills including:

- Technical knowledge
- Cultural awareness
- Analytical skills
- Decision-making
- Interpersonal skills
- Communications skills
- Clinical skills

Qualified Professionals who hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SA services with the population served, **are deemed to have met the requirements of the competency-based employment system.**

Qualified Professionals (other than those described above), associate professionals, and paraprofessionals shall demonstrate competence and have supervision as outlined in the Administrative Rule 10A NCAC 27G. 0203 and 0204.

Competencies must be established and maintained on the schedule outlined in State Plan 2002. Please note that a standardized competency system has not been adopted or defined with finalization by the State at this point, yet this material serves as a guideline.

Reference: http://www.dhhs.state.nc.us/mhddsas/ -- select State Reform Plan "The Plan 2003"; at the top of the page under Reform Implementation, select Previous State Plans; scroll down to State Plan 2002 Staff Competencies, Education and Training.

SUMMARY

Paraprofessional – SUPERVISION AND COMPETENCIES REQUIRED
Education/Experience: High school or GED

Associate Professional – SUPERVISION AND COMPETENCIES REQUIRED
Education/Experience:
Master's in human service field and < 1 year supervised experience
Bachelor's in human service field and < 2 years supervised experience
Bachelor's in other than human service field and < 4 years supervised experience

Qualified Professional –COMPETENCIES REQUIRED EXCEPT FOR **
Education/Experience:
**Anyone licensed, provisionally licensed, certified or registered in human service profession
Master's in human service field and 1 year supervised experience
Bachelor's in human service field and 2 years supervised experience
Bachelor's in other than human service field and 4 years supervised experience

Privileging

If an agency chooses to maintain a system of clinical privileging for the provision of clinical services, staff must be designated as Qualified Professional, Associate Professional or Paraprofessional as defined in Administrative Rule 10A NCAC 27.G0104. Documentation of privileges must be maintained and reviewed *based on agency policy*. Credentialing/privileging is the responsibility of the agency providing MH/DD/SA services, based on the education/experience required for the delivery of services as specified in service definitions.

Records of privileging or staff competencies, along with supporting policies, procedures and documentation, need to be maintained on-site. These records will be reviewed in monitoring by the LME.

DEFINITIONS OF PROFESSIONAL LEVELS

Paraprofessional

Individual (with the exception of staff providing respite services or personal care services) with a GED or high school diploma, or no GED or high school diploma but hired prior to Nov. 1, 2001 to provide mh/dd/sa service.

Supervision shall be provided by a qualified professional or associate professional with the population served.

Associate Professional

Graduate with **Master's degree in human service field** with < one year full-time post-graduate degree accumulated mh/dd/sa experience with the population served

Substance abuse professional with < one year full-time post gruaduate degree accumulated supervised experience in alcohol and drug abuse counseling.

Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience.

Graduate with a **Bachelor's degree in human service field** with < two years full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served

Substance abuse professional with < two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling

Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience

Graduate with a **Bachelor's degree in field *other* than human services** with < four years of full-time post-bachelor's degree accumulated mh/dd/sa experience with the population served

Substance abuse professional with < four years, post-bachlor's degree accumulated supervised experience in alcoholism and drug abuse counseling

Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience

RN who is licensed by the NC Board of Nursing with < four years of full-time accumulated experience in mh/dd/sa with the population served.

Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience

Qualified Professional

An individual who holds a license, provisional license, certificate, registration or permit by governing board of human service profession (except licensed RN, required to also have 4 years full-time accumulated mh/dd/sa experience.)

This includes the following:

Certified Alcoholism Counselor (CAC) – certified as such by the NC Substance Abuse Professional Certification Board

Certified Clinical Additions Specialist (CCAS) – certified as such by the NC Substance Abuse Professional Certification Board

Certified Drug Abuse Counselor (CDAC) – certified as such by the NC Substance Abuse Professional Certification Board

Certified Clinical Supervisor (CCS) – certified as such by the NC Substance Abuse Professional Certification Board

Certified Substance Abuse Counselor (CSAC) – certified as such by the NC Substance Abuse Professional Certification Board

Certified Substance Abuse Prevention Consultant (CSAPC) – certified as such by the NC Substance Abuse Professional Board

Clinical Social Worker (CSW) – licensed as such by the NC Social Work Certification and Licensure Board

Licensed Professional Counselor (LPC) – licensed as such by the NC Board of Licensed Professional Counselors

Psychologist – licensed to practice psychology in NC as either a licensed psychologist or licensed psychological associate.

A graduate with a **Master's degree in a human service field** and one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served

Substance abuse professional who has one year of full-time, post-graduate degree accumulated experience in alcoholism and drug abuse counseling

A graduate with a **Bachelor's degree in a human service field** with two years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served

Substance abuse professional (with BA) who has two years full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling

A graduate with a **Bachelor's degree in a field *other* than human services** and has four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served

Substance abuse professional who has four years of full-tme, post bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling

For more information on specific Rules and updates, please refer to the NC Division of MH, DD and SA services homepage at http://www.dhhs.state.nc.us/mhddsas/ or NC Administrative Rules at http://ncrules.state.nc.us. On this site, reference NC Administrative Code, Title 10A Health and Human Service, Chapter 27 Mental Health.

SAMPLE FORM

REQUEST/REPLY FOR CLINICAL CREDENTIALS

EMPLOYEE:_____ POSITION/TITLE: _____

PROGRAM/LOCATION: _____

SUPERVISOR:_____SECONDARY SUPERVISOR_____

This is (Check one):

__Initial Request
__Change in job responsibilities and/or position
__Change in supervisor
__Annual Review ___Update with changes* __No changes

Clinical Credentials Status*:* *Change in Credentials Requested to be:

____Qualified Professional
____Associate Professional
____Paraprofessional

____Qualified Professional
____Associate Professional

My attached request for credentialing includes supporting documentation:

QP – copy of licensure/certification OR competencies
AP – supervision plan and competencies
PP – supervision plan and competencies

_____ _____
Employee Date Primary Supervisor Date

_____
Secondary Supervisor Date

REPLY TO REQUEST

DATE:_____

Your request for credentials:
____ 1. Approved as requested
____ 2. Q Status: Denied because _____
_____
___ 3. Denied specific credentialing because _____
_____
_____

This request should be re-initiated by_____
Date

Privileging Committee Chairperson

SAMPLE FORM

Staff Name:_____Position/Title:
Supervisor Name:_____Date:
Secondary Supervisor:_____
Clinical privileges shall be reviewed upon hire and updated annually on the employee's anniversary date or in the event of a change in position, job responsibilities, or a change in supervision. The supervisor should check the privileges requested for the clinician based on the duties and responsibilities listed in the current job description. The supervisor should note if the privileges being requested are to be performed independent of supervision, i.e., Full Privileges or With Supervision. The Privileging Committee Chair will review and document whether the privileges will be approved or denied based on a review of all the materials submitted. This is in conjunction with review by the QA Manager as needed for clarification or resolution of privileging questions. **All activities listed on this form requiring supervision must be addressed in the supervision plan.**

Please refer to attached definitions for reference

A. General Skills	**Full Privileges**	**Privileged w/ Supervision**	**Approved**	**Denied**
Access to Medical Records				
Admin/Clinical Supervision				
Assertive Outreach				
Case Consultation				
Clinical Diagnosis				
Consumer Outcome Inventory (COI)				
Employee Assistance Program Contract Management				
Employee Assistance Program Activities (EAP)				
Global Assessment of Functioning Scale (GAF)				

A. General Skills Continued	**Full Privileges**	**Privileged w/ Supervision**	**Approved**	**Denied**
Level of Eligibility (LOE)				
NCSNAP				
Primary Prevention				
Program Consultation				
Quality Improvement/Quality Assurance				
Service Record Entry				
Transportation of Clients				
Treatment/Goal Planning				
Restraint/Seclusion/Isolation				
Protective Devices				
Design/Authorize Restrictive Behavior Management				
B. **Screening/Evaluation**				
Access/Triage				
Admission Assessment (Screening/Intake)				
ADVP Client Evaluation				
Breathalyzer				
Child Mental Health Exams				
Collect-Witness-Perform Drug/Alcohol Screenings				
Commitment Evaluation				

B. Screening/Evaluation Continued	**Full Privileges**	**Privileged w/ Supervision**	**Approved**	**Denied**
Developmental Assessments				
<u>Drug and Alcohol Assessments:</u> DWI SASSI/SALCE DAST MAST MAST-G NC-TOPPS SUDDS IV	_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____		
Emergency Services				
Forensic Evaluation				
Forensic Screening				
Involuntary Screening				
Psychological Testing (Intellectual.Achievement)				
Psychological Testing (Personality/Psychopathology)				
Sexual Offender Evaluation				
Utilization Review				
BASIS 32				
C. Periodic Services				
Adaptive Skills Training				
Adult Developmental Activity Program (ADVP)				

Periodic Services Continued	Full Privileges	Privileged w/ Supervision	Approved	Denied
A&D Education Training (ADETS)				
Case Management				
Case Support				
Mandated Team				
Co-Therapy				
Independent Living				
Day Habilitation				
Crisis Intervention/Stabilization				
Daily Living Supervision				
Day Activity				
Day Treatment				
Family Training (CAP)				
Developmental Day				
Drug Education School (DES)				
Family Living – Moderate				
Family Therapy or Counseling				
Group Therapy or Counseling				

Periodic Services Continued	Full Privileges	Privileged w/ Supervision	Approved	Denied
Community Based Services CBS EIP Individual CBS EIP Group (2) CBS EIP Group (2+) CBS Professional Individual CBS Professional Group (2) CBS Professional Group (2+) CBS Paraprofessional Individual CBS Paraprofessional Group (2) CBS Paraprofessional Grp. (2+)	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Independent Living Skills Training				
Individual Therapy or Counseling				
Money Management				
Non-Hospital Medical Detoxification				
Occupational Therapy/Evaluation				
Parent/Care giver Training				
Personal Assistance				
Personal Care Services				
Physical Therapy/Evaluation				
Pre-vocational Services				
Psychiatric Residential Treatment				
Psychosocial Rehabilitation				

Periodic Services Continued	Full Privileges	Privileged w/ Supervision	Approved	Denied
Recreational Activities				
Residential Treatment - Level I - Level II - Level III - Level IV				
Respite – Non-Institutional				
In-Home Aide				
Sheltered Workshop				
Social Inclusion				
Specialized Educational Services				
Speech Therapy/Evaluation				
Supervised Living				
Supported Employment				
Supported Living - Level I - Level II - Level III - Level IV - Periodic				
Treatment Alternative to Street Crime (TASC)				
Interpreter (CAP)				
Therapeutic Case Consultation				

Transportation (CAP)				
D. Medical Services				
Assessment of Vital Signs				
Medication Administration (IM/IV)				
Medication Administration (Oral/Topical)				
Medication Education				
Medication Management				
Medication Prescription				
Physical Assessment				
Venipuncture				

COMMENTS:

LICENSURE/CERTIFICATION & MANDATORY TRAINING

Staff Name:_____Position/Title:_____
Supervisor Name:_____Date:_____

LICENSURE/CERTIFICATION

A. Licensure **A copy must be attached annually or privileges will be denied.**
(1) Profession:
(2) License Number:
(3) Renewal Date:

B. Certification **A copy must be attached annually or privileges will be denied.**
(1) Profession or Discipline:_____
(2) Certification Number:_____
(3) Renewal Date: _____

MANDATORY/YEARLY:
Check if applicable:

		Date Completed	Renewal Date
1.	Defensive Driving Training **(Every 6 years)**	_____	_____
2.	Blood/Airborne Pathogens **(Annual)**	_____	_____
3.	CPR **(Annual)**	_____	_____
4.	First Aid **(Every 3 years)**	_____	_____
5.	PIC/NCI Training **(Annual)**	_____	_____
6.	Medical Exam **(Annual)**	_____	_____
7.	TB Test **(Annual)**	_____	_____
8.	Fire Safety **(Annual)**	_____	_____
9.	HAZCOM	_____	
10.	Medication Administration **(Annual)**	_____	_____
11.	Medicaid Appeals	_____	
12.	Medical Records	_____	
13.	Confidentiality	_____	_____
14.	Proof of Vehicle Inspection	_____	
15.	Proof of Vehicle Insurance	_____	

Documentation/Verification of training must be attached.

TO BE COMPLETED BY ALL EMPLOYEES AND CONTRACT AGENCY STAFF

SUPERVISION PLAN

EMPLOYEE_____POSITION/TITLE
SUPERVISOR_____POSITION/TITLE
SECONDARY SUPERVISOR_____

When and how often will supervision occur:(X number of times per month for X number of hours)

Nature of supervision:(group, peer, individual, staff):

Format: (direct observation, case discussion, record review, co-therapy)

How and when will employee give feedback to supervisor regarding supervisory process?
_____

Specify supervisory needs, goals, and training

_____

□ **relevant to privileged areas requiring supervision.**

This plan is in effect for one year from the date below or until fully qualified status is achieved. A year from this date the supervisor and employee shall review the progress toward these goals and submit a new supervision plan if qualified status has not been achieved. This report shall be maintained in the employee's personnel file.

_____ _____Employee/Date
Supervisor/Date

_____
Secondary Supervisor/Date

Client Rights Reporting: ***The Provider must meet the minimum requirements of the Division MH/DD/SA Client Right's rules as referenced in Section2.5 of the Agreement and any additional requirements specified in the Area Authorities formal Client Rights Policy (see section III), if more restrictive than Division requirements.***

The Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of Individuals while in its care and to ensure compliance with all state and federal reporting requirements, other applicable rules and statutes related to Individuals' rights. The Provider agrees to maintain policies, procedures and monitoring as required in the State Client Right's policy and all subsequent revisions outlined in the Provider Manual, Section I and II (reference APSM 95-2, GS 122C, Article 3), and the Divisions' Client Rights policy and standards. It is also the responsibility of the Provider to appoint a Client Rights Committee, which will meet at least once each calendar quarter with minutes of each meeting submitted to the Area Authority within 30 days of the meeting.

Sample copies of policies outlining the required components of a Clients Rights Committee and Restrictive Intervention Policy are available upon request by contacting Doug Gallion (dgallion@catawbacountync.gov) or John Waters (jwaters@catawbacountync.gov)

Restrictive interventions are to be documented and filed in the consumer's record (SEE ATTACHED SAMPLE FORM). All restrictive interventions should be reviewed by a Client Rights Committee.

Report of Restrictive Intervention

Client Name:_____ **Record #:**_____

Provider: _____

Date of Restrictive Intervention: _____

1. **Brief description of what happened to cause a restrictive intervention and actions leading to the behavior**:
   (Include frequency, intensity, duration of behavior, specifics of behavior, rationale for use of intervention)
   _____
   _____
   _____
   _____
   _____

2. Attempted positive and/or less restrictive interventions (check all those attempted):

☐ Verbal Redirection
☐ Removing client from situation
☐ Impromptu treatment session
☐ Separation from group
☐ Offered distractions (e.g. take a walk)
☐ other

Results: _____

3. Purpose of the intervention/description (check all that apply):

Emergency Use for:
☐ Prevent harm to self
☐ Prevent harm to others
☐ Prevent serious property damage

☐ Planned intervention (Tx Plan date:_____ *Prior approval required through client rights)

4. Intervention and amount of time used (e.g. __x__ physically restrained for 5 minutes):

☐ Physical Restraint: Minutes ☐ Isolation-Time Out: _____ Minutes

☐ Other: _____ _____ Minutes

If you chose OTHER in the above, please describe:
_____

Type of hold used: _____

5. Additional time authorized and by whom: (required only for restraints over 15 min.)

Amount of additional time authorized: _____

Name: _____ Title: _____

Health Status:

a. Date of last physical:_____
b. Significant medical conditions identified previously:

☐ Asthma
☐ High Blood Pressure
☐ Heart Condition
☐ Physical disabilities
☐ Other:
_____
_____

☐ Medications: (list)_____
_____
_____
_____
_____
_____
_____

HEALTH CHECK	ITEM	INITIAL CHECK	ENDING CHECK	
	Consciousness	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Speech	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Breathing	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Movement	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Skin Color	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Orientation	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			
	Affect-Mood	☐ **NORMAL** ☐ **NOT**	☐ **NORMAL** ☐ **NOT**	
	If not normal please explain:			

Brief description of client's response to intervention (note judgement and insight):

_____
_____
_____
_____
_____

6. Debriefing with Client:

_____
_____
_____
_____
_____

Staff Signature with Title: _____Date: _____
(Signature of Staff Completing Form is required)

Supervisor Action

State any immediate action taken: (including debriefing of staff)

_____
_____
_____
_____
_____

What actions have been taken to aid in preventing this from happening in the future?

_____
_____
_____
_____
_____

Individuals Contacted: (Parent, Guardian, Case Manager, etc.)
Means of Notification: (phone, note or in person)

Person contacted: _____(relationship)_____
Date:_____
Contacted By:_____
Method of contact: _____

Supervisor's Signature: _____ Date: _____
Case Manager's Signature: _____Date: _____
Clinical Director's Signature: _____Date: _____
Client Right's Committee: _____Date: _____
CRC Recommendations:

_____
_____

Forward Original Form to Client Rights Coordinator/Appropriate Personnel within 24 Hours of Incident

Incident Reporting: ***All incidents pertaining to Area Authority clients shall be reported to the Area authority as required in APSM 95-2(Client rights) and APSM 30-1 (Quality Assurance/Improvement).***

The Provider will make a verbal report of **any** incident to the case manager within 24 hours, but in no event later than the following working day. If this is, or could possibly become a critical incident, such notification **must be immediate**. A written confirmation of the verbal incident report, using the Area Authority's applicable incident report form, shall be submitted within three- (3) working days. All deaths will be reported directly to DFS or DMH/DD/SAS, as appropriate. The Provider will follow state reporting regulations pertaining to any incidents resulting in death. Additionally, the Provider will immediately notify the Area Authority of any death.

The Provider shall give immediate written notice to the Area Authority of all accidents or claims of any kind whatsoever arising out of the Provider's performance under this Agreement, and shall cooperate fully with the Area Authority or its representatives in the investigation, handling or prosecution of any such claim. By executing this Agreement, the Provider authorizes the release of any police, medical or accident reports to the Area Authority. This release will survive the termination of this Agreement.

This Critical Incident Report Form and instructions on completing the form may be found on the Division website. Click on Manuals and Forms, then find the Critical Incident Report Form. Additionally, these forms may be found in the accompanying packet of forms with this Provider Manual.

This form is used to report critical incidents and deaths for any person receiving mental health, developmental disabilities and/or substance abuse (mh/dd/sa) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of periodic or community-based mh/dd/sa services must submit the form. Failure to complete this form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license or enrollment. NOTE: Effective July 1, 2003, this form also replaces the Report of Death to DHHS Form for reporting deaths from unnatural causes.

***Instructions*: Complete and submit this form within 72 hours of a critical incident or death. ♦ In addition, report immediately deaths that occur within 7 days of restraint or seclusion of a client to NC Division of Facility Services. ♦ Complete one form for each client and submit to the host and home area authorities/county programs. ♦ If requested information is unavailable, provide an explanation on the form and report the additional information as soon as it becomes available.**

PROVIDER INFORMATION

Host area authority/county program:_____

Provider name:_____ Unit, ward or group home *(if applicable)*:_____

Address:_____ City:_____ County_____

Director / CEO:_____ Phone Number:_____

Provider Medicaid Number:_____ Facility License Number *(if applicable)*:_____

Name & title of first staff person to learn of incident _____

CLIENT INFORMATION

Date of incident: ____/____/____ Time of incident: ___: ___ ☐ a.m. ☐ p.m. Client Medicaid Number: _____

Client Date of Birth: ___/___/____ Client Gender: ☐Male ☐Female Weight:____lbs *(for deaths)* Height:____ft ____in *(for deaths)*

Client Ethnicity (*Check all that apply*)

☐ White ☐ Hispanic/Latino ☐ Black/African American

☐ Asian ☐ Native American ☐ Other *pecify)*:_____

All mh/dd/sa diagnoses:

_____

_____

_____

Client's home area authority/county program *(if different from above)*:_____

Was the client treated by a physician for the incident? ☐ Yes ☐ No Date of treatment: _____/_____/_____

TYPE OF INCIDENT

DEATH

(Check only one)

Client death due to:

☐ Terminal illness or other natural cause

☐ Unknown cause

☐ SUICIDE

☐ ACCIDENT

☐ HOMICIDE / VIOLENCE

FOR ANY DEATH UNDERLINED ABOVE:

Complete the *Reportable Deaths* section, Page 2 *and* mail or fax a copy of this entire form to DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077

ABUSE, NEGLECT, OR EXPLOITATION

(Check all that apply)

☐ Alleged abuse of a client.

☐ Alleged neglect of a client.

☐ Alleged exploitation of a client.

Verbally report any suspected case of abuse, neglect or exploitation of a consumer to the county Dept. of Social Services.

INJURY REQUIRING TREATMENT BY PHYSICIAN

(Check only one)

☐ Suicide attempt.

☐ Injury from use of a hazardous substance.

☐ Self-injury.

☐ Injury caused by another client.

☐ Other accident or injury.

MEDICATION ERRORS

Report medication errors that cause discomfort or that place a client in jeopardy

(Check only one)

☐ Missed dose of prescription medication.

☐ Wrong dosage administered.

☐ Wrong medication administered.

OTHER INCIDENTS

(Check all that apply)

☐ Client absence without notification for more than 3 hours.

☐ Suspension of a client from services.
Number of days suspended: _____

☐ Expulsion of a client from services.

☐ Arrest of a client for violations of state, municipal, county or federal law.

☐ Fire or equipment failure that has resulted in death or injury.

RESTRAINT & SECLUSION

Was the client restrained or in seclusion at the time of the incident? ☐ Yes ☐ No If yes, check applicable boxes below.

☐ Physically Restrained ☐ Chemically Restrained ☐ In Seclusion Duration: _____hours _____minutes

Only restraint or seclusion that results in abuse, neglect, injury or death needs to be reported on this form. However, all use of restraint or seclusion must be documented in the client's record, as required by the North Carolina Administrative Code. Providers using a standardized restraint & seclusion form are encouraged to submit that document with this form.

Did death occur within 7 days of restraint or seclusion of the client? ☐ Yes ☐ No

FOR ANY DEATH THAT OCCURS WITHIN 7 DAYS OF RESTRAINT OR SECLUSION*, complete the Reportable Deaths section on Page 2 and immediately mail or fax a copy of this entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077*

REPORTABLE DEATHS

Complete only for <u>deaths from suicide, accident, homicide, or violence</u> or deaths occurring <u>within 7 days of restraint or seclusion</u>.

Address where client died: _____

Dates of last two (2) medical exams *(if known)*: _____/_____/_____ _____/_____/_____ Adjudicated incompetent?

Date of most recent admission to a state mh/dd/sa facility *(if known)*: _____/_____/_____ ☐ N/A ☐Yes ☐No

Date of most recent admission to a hospital for physical illness *(if known)*: _____/_____/_____ ☐ N/A

Physical illnesses/conditions diagnosed prior to death: _____

(attach additional pages as needed)

CIRCUMSTANCES OF INCIDENT

LOCATION OF INCIDENT

☐Provider premises ☐Client legal residence ☐School ☐Workplace ☐Community

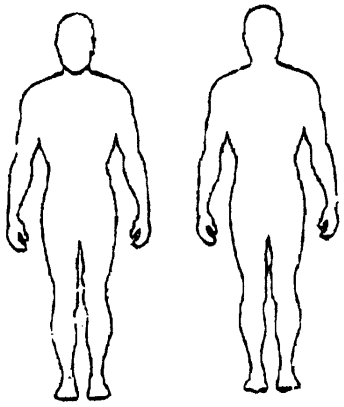
☐Other *(specify)* _____

DESCRIPTION OF INCIDENT

Include <u>who</u> (both participants and witnesses), <u>what</u>, <u>why</u>, and any other relevant information. ***(Attach additional pages if needed.)***

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



FRONT BACK

INTERNAL RESPONSE

Describe any <u>investigation</u> done to determine the <u>cause of the incident</u> and <u>projected date of completion</u>. If investigation is not completed or necessary, explain why *(attach additional pages as needed)*:

Describe any <u>corrective measures</u> that have been or will be put in place as a result of the incident and <u>person(s) responsible</u> for ensuring implementation *(attach additional pages as needed)*:

Indicate <u>other authorities or persons</u> that have been notified of the incident *(where applicable)*:

☐ County DSS Contact Name: _____ Date ____/____/____

☐ Law enforcement Contact Name: _____ Date ____/____/____

☐ Case Manager Contact Name:_____ Date ____/____/____

☐ Client's Home Area Program Date ___/___/___ ☐ DFS Mental Health Licensure & Certification Section Date ____/____/____

☐ Parent / Guardian Date ___/___/___ ☐ DFS Health Care Personnel Registry Date ____/____/____

☐ Other _____ Date ____/____/____

Name & title of person preparing report *(Please print)*:_____

Signature _____ Date _____/_____/_____ Time ____:____ ☐ a.m. ☐ p.m.

Confidentiality of client information is protected. Use this form according to confidentiality requirements in NC General Statutes and Administrative Code and in the Code of Federal Regulations.

<u>Direct any questions to:</u> DMH/DD/SAS Accountability Team Phone: (919) 881-2446 FAX: (919) 881-2451

<u>Send all forms</u> by mail, fax or protected email <u>within 72 hours</u> of incident to the host and home area authorities/county programs.

<u>For reportable deaths</u>, also send a copy of the entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077

Person-Centered Planning:

As stated in *State Plan 2003: Blueprint for Change*, "At the heart of reform efforts is person-centered planning. Person-centered planning is the life planning process that applies across all citizens who are supported and served. Person-centered planning is not a program. Person-centered planning is a life planning method (process) of determining ends (real life outcomes) for individuals and developing means to those ends (strategies)."

SP2003, pp. 46-48, on the Division website, details the process, real life outcomes, and strategies of person-centered planning.

Best Practices

State Plan 2003, Chapter 3, on the Division website, present best practice protocols for each disability group. Additionally, a resource listing for the best practice areas for each of the four disability groups (adult mental health, child mental health, developmental disabilities and substance abuse) are included as appendix A in the plan.

Adult Mental Health Best Practice – pp. 50-59
Child Mental Health Best Practice – pp. 59-74
Developmental Disabilities Best Practice – pp.74-77
Substance Abuse Best Practice – pp.78-94
Appendix A – resource listing

Model Fidelity/ Treatment Protocols

Until more information is available from the Division, resources including training forum dates and toolkits on Evidence-Based Practices/ Best Practices are available on the following website: http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp.

Clinical Outcome Measures:

The LME, through Providers, will collect outcomes information on its consumers following sampling methods and reporting schedules for the instrument being used. The appropriate outcomes instrument use depends on the type of consumer and a transition schedule for the LME

1. The EI COI is required for consumers up through five years of age whose case numbers end in 3 or 6
2. The DD COI is required for consumers with a primary disability of developmental disabilities ages 6 and older, and who case numbers end in 3 or 6
3. The NC TOPPS is required for all consumers in specified substance abuse populations
4. The MH/SA COI is required for all other consumers with a primary disability of mental health and/or substance abuse who case numbers end in 3 or 6 until transition to the web-based NC TOPPS system. (A transition plan will be made with the LME to move new and existing consumers to the expanded NC TOPPS system at an agreed-upon time during the fiscal year. By the end of the fiscal year, all MH/SA clients ages six and older will be using the NC TOPPS system.)

The COI is to be administered initially, and at 3 mos., 6 mos., annual update, and termination.
The NC TOPPS is to be administered initially, and at 3 mos., 6 mos., and annually

The LME will continue to identify and develop applicable outcome measures even beyond the scope of clinical efficacy, for use in gathering data to analyze trends, patterns, etc. in Provider performance for consumers. QA/QI initiatives will employ input from Providers as these tracking measures are identified. Ultimately, clinical, customer satisfaction and performance outcome reports will be used to maintain or impove quality

service provision throughout the Provider network. Additionally, data will be used to gauge the need for expanded or more specialized Provider network capabilities.

Section VII
Area Authority-Specific Forms

A packet of MHSCC forms has been included with this Provider Manual.

If questions or needs arise regarding forms, please contact Wendy Powers in the Medical Records Unit.

Section VIII
Glossary of Terms

Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing State and Area Authority documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.
ACCREDITATION – Certification by an external entity that an organization has met a set of standards**.**
ACT-Assertive Community Treatment
ADULT- means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies**.**
ADMINISTRATIVE SERVICES- means the services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractors decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.
ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes**.**
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field**.**
AOC - Administrative Office of the Courts.
APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided**.**
APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.371.
ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.
AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement. *PRE-AUTHORIZATION/PRIOR AUTHORIZATION* is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer's progress toward outcomes, the use of natural and community supports, and how the requested services will support the outcome the individual is seeking. *RETROSPECTIVE AUTHORIZATION* is authorization to provide services after the services have been delivered.

BASIC SERVICES – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.
BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations. *BENEFIT LIMITATIONS* are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* are medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.
BEST PRACTICE (S) – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.
BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and

programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services. It is an administrative Service Management Function performed by the Contractor for individuals not enrolled or not meeting target population definitions.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the state served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CERTIFICATION – A statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Contractor or the NC Council may be the certifying agency for subcontracted **Providers.**

CFAC - Consumer and Family Advisory Council

CHILD-means an eligible person who is under the age of I8, unless the term is given a different definition by statute, rule or policies.

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, INVESTIGATING, paying, and otherwise processing service claims submitted by network and facility providers. *CLAIM* – An itemized statement of services, performed by a provider network member or facility, which is submitted for payment. *CLEAN CLAIM*- means a claim that successfully passes all adjudication edits.

CLIENT - An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE (CDW)- The DHHS's source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and quality management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse**.**

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS –Terms that reflect the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc) and require specialized approaches.

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement**.**

CONSUMER- An individual who is admitted to or receiving public services. "Consumer" includes the consumer's personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE (CFAC) – A Board appointed group of persons receiving services, families of persons receiving services, advocates and other stakeholders that participate in meaningful decision making relative to the local program. The group shall meet at least monthly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - an organization or entity agreeing by signature to provide the goods and services in conformance with the stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-a period from July I of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services which the enrolled person pays directly to the Contractor or the subcontracted providers at the time covered- services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.

CORPORATE COMPLIANCE – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with compromise a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself. *CRISIS RESPONSE* is the immediate action to assess for acute MH/DD/SA service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year. These services may be referred to as *EMERGENCY* services as well. NC requires a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events.
CULTURAL COMPETENCE/PROFICIENCY –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.
CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* -the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* - those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* -those groups and individuals outside the system that have a take in the outcomes and products produced by the system.

DD - Developmental Disability
DEFAULT – The breach of conditions agreed to in this Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.
DE-INSTITUTIONALIZATION – Release of people from institutions to care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in OLMSTEAD V. LC has given new momentum to development of community based services for individuals who have remained in state hospitals and mental retardation centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees state government human services programs and activities.
DEVELOPMENTAL DISABILITY (DD) - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay.
DHHS- Department of Health and Human Services.
DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.
DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.
DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a state hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North
Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.
DJJDP - Department Of Juvenile Justice and Delinquency Prevention.
DOMAINS - Major areas of concern to the NC public MH/DD/SA system and its mission, goals, and strategies and for which indicators and measures are developed to examine outcomes of service in the lives of people served.
DPI -Department of Public Instruction
DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES
(EPSDT) – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices**.**
ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.
EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.
EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: o The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. o The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. o The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.
ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number**.**

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by state and federal law and regulations.
FEE FOR SERVICE – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.
FEMA - Federal Emergency Management Agency
FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.
FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications.
FUNCTIONAL OUTCOMES - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing, employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GAPCD - Governor's Advisory Council for Persons with Disabilities
GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.
GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles**.**
GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other non-appropriated funds.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) –Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of electronic and paper-based patient information, and mandates "best effort" compliance.
HIPAA - Health Insurance Portability and Accountability Act
HUD - Housing and Urban Development
HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.
INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.
IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) –Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan
LEAST RESTRICTIVE CARE – The service that can be provided in the most normative4 setting while insuring the safety and well being of the individual.
LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.
LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, as used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement ranging from inpatient to outpatient**.**
LICENSURE – A state or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.
LME - Local Management Entity
LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.
LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.
LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.
MEDICAID – A jointly funded federal and state program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal government requires that the state/local government match the federal government funds. In North Carolina, this is approximately 60% federal/40% state/local match. People qualifying for Medicaid are "entitled" to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.
MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.
MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.
MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with long term disabilities.
MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.
MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.
MH - Mental Health
MMIS - Medicaid Management Information System.
MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURRANCE (NCQA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.
NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.
N**ATURAL AND COMMUNITY SUPPORTS** - Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.
NCQA - National Council for Quality Assurance
NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.
NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OPERATIONAL AND FINANCIAL REVIEW-means the review of the Contractor conducted by DMH/DD/SAS to assess compliance with contract requirements.
OUTREACH - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.
PCP - Person Centered Plan
PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.
PEER REVIEW – The analysis of clinical care by a group of that clinician's professional colleagues. The provider's care is generally compared to applicable standards of care, and the group's analysis is used as a learning tool for the members of the group.
PENETRATION – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders.
PERFORMANCE INDICATORS - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.
PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations and in meeting them the agency or provider may meet a required level for "certification" or "accreditation".
PERSON-CENTERED PLANNING - A process focused on learning about an individual's whole life, not just issues related to the person's disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MH/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and the services being requested from the public system to achieve the consumer's desired outcomes. The plan is used as the basis for requesting an authorization for services.
PHYSICAL DEPENDENCE - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.
PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.
PP - Primary Provider
PREVALENCE – The estimated degree of incidence of a condition in a given population.
PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach the general population; Selective Prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention programs are designed for people who are already experiencing mental illness or addiction disorders.
PSR - Psychosocial Rehabilitation
PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

PRIMARY SOURCE VERIFICATION – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.
PRINCIPAL DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.
PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.
P**RIVILEGING** – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.
PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 7 days, initial hospital discharge visits within 5 days, urgent visits within 2 days, emergent visits immediately and no later than 2 hours qualify as prompt.
PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.
PROVIDER MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.
PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.
PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly funded services to consumers.

QA - Quality Assurance
QI - Quality Improvement
QIC - Quality Improvement Committee
QM - Quality Management
QPN - Qualified Provider Network
QUALIFIED PROVIDER NETWORK – The group of subcontractors subcontracted by a Contractor to provide supports and services to persons for whom the Contractor authorizes care.
QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial performance. Processes include: QUALITY ASSURANCE, and QUALITY IMPROVEMENT. QUALITY*IMPROVEMENT (QI)* is a process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers and administrative functions. *QUALITY ASSURANCE (QA)* involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.
RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.
REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow–up in a timely manner consistent with best practice guidelines.
REGISTER – The process of gathering initial data and entering an individual into the service system.
RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.
REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse
SAPT - Substance Abuse Prevention and Treatment
STATE-means the State of North Carolina.
STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statue and titled "Blueprint for Change".

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services.

SEVERELY MENTALLY ILL (SMI) – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of state facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline's peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single state agency designated by each state's governor to be responsible for the administration of publicly funded mental health programs in the state. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This statewide plan forms the basis and framework for MH/DD/SA services provided across the state.

STATE OR LOCAL CONSUMER ADVOCATE - The individual carrying out the duties of the state Local Consumer Advocacy Program Office **SUBSTANCE ABUSE** – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) -A federal program to provide funds to states to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1year period.

SUBCONTRACT-means any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The *SUBCONTRACTOR* means any third party engaged by the Contractor, in a manner conforming to the contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires states to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from states that fail to comply with the SYNAR Amendment.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language. *NON-TARGET POPULATION* are those individuals with less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.
TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management
UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.
UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.
UTILIZATION-is the use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.
UTILIZATION REVIEW (UR)- is an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.